Holy Name of Jesus School
6190 Allentown Blvd. Harrisburg, PA 17112
Phone: 657-1704/Fax: 657-9135

Authorization for NON-PRESCRIPTION Medication – Confidential

Name of Student: ____ Date of Birth: ____________________

Homeroom: __________ Medication: ____

Manufacturer's recommended dosage: ____

Time(s) of day medication is to be given: ____

____

Common side effects: ____

Special instructions by parent/guardian: ____

____

Has your child **ever** received this medication? ☐ Yes ☐ No**

****School personnel are prohibited from giving the first dose of any medication.**

All medication must accompany this form and be provided in its original container with a legible label.
The parent/guardian must bring all medications to the Health Room.

I understand that some nonprescription medications, which may include the above listed medication, might cause my child to suffer an adverse reaction or other serious medical condition. I hereby release, waive, discharge and covenant not to sue the Diocese, Parish, School or their employees, officials, agents or volunteers for any liability for damages, injury or death that may result from ill effects or adverse reactions to this medication.

I authorize this medication to be administered at the School by staff persons or volunteers who are not physicians, licensed registered nurses (RNs), or licensed practical nurses (LPNs). I understand, acknowledge and approve that the individuals administering the medication do not have any form of medical license and will not perform a medical assessment of my child prior to administering the authorized medication.

Further, I acknowledge that the School bears no responsibility for ensuring the medication is administered and that the Diocese, Parish, School or their officials, employees, agents or volunteers may decline to administer the medication. If the School declines to administer the medication, the School will take reasonable steps to notify you that the medication will not be administered.

I HEREBY CERTIFY THAT I HAVE READ THIS DOCUMENT IN FULL *(front and back)* AND THAT I HAVE THE LEGAL AUTHORITY TO CONSENT TO THE ADMINISTRATION OF THIS MEDICATION.

Date ____________ Signature of parent/guardian ______________________________

Printed Name ____

Date ____________ Witness (school employee) ______________________________

Printed name ____

turn over

For School Use only:

Name: ___________________________ Homeroom ___________

NOTE:
Nonprescription medication may be given for a specific, time-limited minor illness or for intermittent medical conditions. **If the medication is needed for more than ten doses, a prescription may be necessary in order for the medication to continue to be given at school.** The medication must be provided in its original container with a legible label, and authorized for the dosage recommended for children on the package. Authorization for nonprescription medication administered at school is required by the School.

Name of Medication, frequency, and dosage: ____

Date/ Time/initials	Date/ Time/initials	Date/ Time/initials	Date/ Time/initials	Date/ Time/initials
Date/ Time/initials	Date/ Time/initials	Date/ Time/initials	Date/ Time/initials	Date/ Time/initials

THIS RELEASE IS TO BE RETAINED IN STUDENT'S MEDICAL FILE.

Special Note:
____
____

Initials: ________________________________
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____
____
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____
____

Location: ________________________
____
____

Meds picked up by: ____________
Date: ____________